

Series editor: David Taylor

Minister without portfolio?

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A view of appraisal

To minister: *to attend to the needs (of) Portfolio: a flat case, esp. of leather, used for carrying maps, drawings etc.* (Collins English Dictionary)

“Good morning. Please sit down. Thank you for coming for your appraisal. Can I see what evidence of your good medical practice you have brought with you?”

By 31 March 2002 all consultant ophthalmologists practising in the United Kingdom should have been appraised. As appraisal has been an essential part of training for senior house officers and specialist registrars for several years, all ophthalmology doctors will be involved in the activity. The actual process for appraisal will vary from trust to trust but the Department of Health has produced instructions regarding the nature of the documentation that the appraisal meeting must produce.¹ The basis for any appraisal discussion will be the evidence of good medical practice² that each consultant brings. Such evidence will be collected into some form of carrying case, not necessarily flat, or indeed made of leather, but none the less it could be called a *portfolio*.

So how is your portfolio coming along? Or do you minister without a portfolio?

While there may be a wide range of responses from ophthalmologists to the need to produce a portfolio, such responses could fall into one of two broad categories.

(1) The “if I have to do it, I will, but don’t expect me to engage in it” category

(2) The “if I have to do it, I may as well see if I can get something out of it” category.

Whatever category you feel you are in as you read this, the following, which is largely drawn from the Association for Medical Education in Europe Guide No 11: Portfolio-Based Learning and Assessment,³ may be of some use.

What is a portfolio?

There are several definitions in addition to the one already referred to. A financial definition is “a list of financial assets, such as shares, bonds, bills of exchange etc,” but the more relevant educational definition of a professional development portfolio is “a collection of material, made by a professional, that records and

reflects on, key events and processes in that professional’s career.”⁴ The key features of such a portfolio are that the content is at the discretion of the professional (or learner; but aren’t they the same thing?) and that the contents have been reflected upon—that is, some learning has taken place as a result of the activity that produced that part of the portfolio.

But what is the evidence for their use?

At a time when all of our practice is scrutinised for the evidence for its use, it is right to ask about the evidence that supports the use of a portfolio in appraisal and assessment for trainees and those who are considered trained, but still learning. The results from a randomised clinical trial with real and placebo portfolios are not yet available, but there is an educational basis for their use.

(1) It is self evident that if asked to produce some evidence of professional practice it is better to have something—for example, a portfolio, rather than nothing at all.

(2) Adult learners, which I assume we are, respond best to learning strategies that are interactive, relevant, related to experience, and reflective in nature.³ A portfolio meets these requirements.

(3) Descriptions of how professionals practise and learn through their practice emphasise the need to reflect on what they have done.³ This can be achieved for procedures or well defined care pathways that have recognised standards through audit. Individual encounters with patients are better dealt with as critical incidents that have prompted learning. Portfolios can incorporate both processes of reflection followed by action.

What goes into a portfolio?

The categories of evidence to support appraisal have now been determined by the Department of Health and are based upon good medical practice.² The sort of material that can be utilised is wide ranging, and the following list is far from exhaustive:

- Patient encounters that have led to some learning. This is the basis of the casebook for the exit assessment for the Royal College of Ophthalmologists

- Details of attendance at postgraduate teaching. This is of more value if it includes some reflective comments on what was actually learned or how practice was altered
- Audits, especially where practice was changed and there was an improvement in some aspect of patient care
- Involvement in teaching. This is enhanced if details of preparation and an evaluation of success of formal teaching are included. Reflecting on teaching those that you supervise. Strategies for teaching surgery. Balancing the needs for teaching and delivering a service
- Research activity, both successful and unsuccessful. How the idea for the research came about, writing the protocol, interaction with the ethics committee, and recruitment are as important, from an educational point of view, as the final published paper
- Managing your practice and the practice of others. Developing or modifying a service, working with others to achieve a change in service provision. How you chair or contribute to meetings
- Feedback from others, whether sought or spontaneously given. Complaints and praise and how you responded.

Having prepared a portfolio, what is one to do with it?

Clearly, one use of a portfolio is to support appraisal, the record of in-training assessments or RITA (if you are in training) and revalidation when it arrives. However, to collect material for a portfolio purely for an “event” is missing out on its main value.

If learning is truly lifelong and largely self determined (within broadly defined professional requirements), then a portfolio allows the learner to plan and monitor progress. This may be an activity conducted in isolation or as part of a group.

If appraisal works well, the outcome will be a feasible, agreed personal development, learning, or action plan. As the portfolio matures it will include several of these plans and evidence of how they have been achieved.

Validly and reliably assessing the competence of any practitioner is difficult and certainly not possible by one method on its own. As part of a strategy for the assessment of competence, a portfolio has at least high face and content validity and some measure of construct validity.⁵ Its impact on learning has yet to be assessed but the reflective aspects of a well constructed portfolio lead to deeper learning, and are preferable to a list of attendances at conferences where the

depth of learning (or even level of consciousness) is in doubt.

The Royal College of Ophthalmologists will be producing guidance on the preparation of a GMC revalidation folder. Some aspects of this folder will be prescribed but will not contradict anything described above. Appraisal is here. Trainees have RITAs.

Can you still minister without a portfolio?

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ECHO

Genetic background affects expression of a mitochondrial mutation



Please visit the British Journal of Ophthalmology website [www.bjophthalmol.com] for link to this full article.

New evidence from an in vivo study supports the hypothesis that the genetic background of specific tissues can influence expression of a maternally inherited mutation causing blindness.

The study was performed in a family of four harbouring point mutation *G3460A* in mitochondrial DNA (mDNA), which had resulted in Leber's hereditary optic neuropathy (LHON) in the only son at age 18 years. His mother and his twin sisters were unaffected.

The proportion of mutant mDNA in whole blood, platelet and leucocyte fractions, and uroepithelial cells was compared within the family. The three siblings had 100% mutant mDNA in all cell types tested whereas their mother had 56–24%, depending on cell type.

The mutation's known effects in inhibiting activity of the mitochondrial respiratory chain and oxidative phosphorylation were investigated by phosphorus magnetic resonance spectroscopy of the occipital lobe of the brain and of calf muscle. All family members showed abnormalities in measures of oxidative phosphorylation in the brain compared with 35 healthy controls. The measures in calf muscle were within normal range and similar to values in the controls.

The researchers think it unlikely that muscle tissue would differ in its mDNA from the other cell types tested and conclude that tissue specific expression of the mutation is due to differences in the nuclear background.

LHON is the commonest cause of isolated blindness in young men, with the *G3460A* mutation accounting for up to 19% of cases. A previous cell study suggested that changing the nuclear background might influence biochemical expression of this mutation.

▲ *Journal of Neurology, Neurosurgery, and Psychiatry* 2002;**72**:805–807.